PRINTED: 05/24/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED		
			B. WIN	B. WING			/2012	
NAME OF E	PROVIDER OR SUPPLIE	R	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
					EST 14TH STREET			
MARION	REHABILITATION	I AND ASSISTED LIVING CENTE	₹	MARIO	N, IN 46953			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG K0000				TAG	DEFICIENCY)		DATE	
KUUUU								
	An Initial Life	Safaty Coda	K00	000				
	An Initial Life Safety Code Certification and State Licensure			I Noodo				
	· ·	nducted by the						
	Indiana State [•						
		rdance with 42 CFR						
	483.70(a).							
	Survey Date: 05/09/12 and							
	05/10/12							
	Facility Numbe	er: 012809						
	Provider Numb	per: 012809						
	AIM Number:	NA						
	Surveyor: Am	y Kelley, Life Safety						
	Code Specialis	it						
	At this Initial L	ife Safety Code						
		Rehabilitation and						
	I	g Center was found						
	not in complia							
		for Participation in						
	Medicare/Med	-						
	I	0(a), Life Safety						
		the 2000 Edition of						
	the National Fi							
		FPA) 101, Life Safety						
		napter 18, New						
		ccupancies and 410						
	IAC 16.2-3.1-	19, Environment						
	and Physical Standards of the							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MWL621

Facility ID:

012809

TITLE

PRINTED: 05/24/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPL	(X3) DATE SURVEY COMPLETED 05/10/2012	
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Ε	(X5) COMPLETION DATE	
		Facilities Rules for e care facilities.						
	to be of Type V and was fully s facility has a fill with smoke der areas open to t resident rooms capacity of 70 0 at the time of Quality Review by Code Specialist-Me The facility was compliance wit aforementioned	nt was determined (111) construction prinklered. The re alarm system tection in corridors, the corridors and in reference and in reference and the corridors and in reference and had a census of fithis survey. Robert Booher, Life Safety dical Surveyor on 05/15/12.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MWL621

Facility ID: 012809

If continuation sheet

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PRINTED: 05/24/2012 FORM APPROVED OMB NO. 0938-0391

K0040 NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type with openings of at least 41.5 inches wide. Doors in exit stairway enclosures are no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5 Based on observation and interview, the facility failed to ensure 5 of 10 exit doors had a clear width no less than 41.5 inches wide. LSC 18.2.3.5 requires the clear width of doors		
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER (A4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SS=E LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type with openings of at least 41.5 inches wide. 18.2.3.5 Based on observation and interview, the facility failed to ensure 5 of 10 exit doors had a clear width no less than 41.5 inches wide. LSC 18.2.3.5 requires the clear width of doors STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953 STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953 STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953 STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953 STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953 STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953 DEPONITION OF CORRECTION COMMENT OF CORRECTION SHOULD BE CALL OF COMMENT OF COMMEN		
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MARION REHABILITATION AND ASSISTED LIVING CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0040 SS=E		
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inches wide. LSC 18.2.3.5 requires the clear width of doors		
requires the clear width of doors		
in the means of egress from		
nursing homes shall be no less		
than 41.5 inches. This deficient		
practice could affect residents on		
the D and E wings.		
Findings include:		
Based on observation with the		
Project Superintendent, Director of		
Operations and the Administrator		
on 05/09/12 from 4:21 p.m. to		
5:05 p.m., the D wing's north,		
west and south exit doors and the		
E wing's north and south exit		
doors had a noticeably smaller		
·		
opening then the remaining exit		
doors. Measurement taken by the		
Project Superintendent at the time		
of observations confirmed the exit		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	01		LETED 0/2012		
	PROVIDER OR SUPPLIER REHABILITATION AND ASSISTED LIVING CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	door openings were thirty five inches wide.						
	3.1-19(b)						

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Event ID: MWL621

Facility ID: 012809

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